

# HSM SMALL GROUPS :: REGISTRATION FORM

## STUDENT INFORMATION:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Gender:  Male  Female Birthday: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Grade (entering in fall 2009):  9  10  11  12 School: \_\_\_\_\_

Has this student been involved in a Saddleback small group before?

Yes  No

Has this student accepted Jesus as their personal Savior?

Yes  No

Has this student been baptized?

Yes  No

Does this student regularly attend the HSM weekend service?

Yes  No

## GROUP INFORMATION:

Day of the Week Preference:

Tuesday  Wednesday  Either

Group Preference:

- As close to home as possible
- With other students from my school
- With a specific leader

\_\_\_\_\_  
 With a specific friend

\_\_\_\_\_

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## PARENT INFORMATION:

Parent's Name: \_\_\_\_\_

Parent's Email Address: \_\_\_\_\_

I would like to receive HSM parent updates.

Yes  No

Home Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I would like more information about leading a SMALL GROUP.

Yes  No

I am interested in being a Host Home.

Yes, please send me more information  No

## PARENT PERMISSION:

I am the parent, legal guardian, or the care giver who is a relative of, and who, under Section 6550 under the California Family Code, may authorize medical and dental care for Minor to take part in and or all HSM Small Group Events and all activities involved with each event between the dates of September 2009 and June 2010. I hereby authorize Saddleback Church, into whose care Minor had been entrusted, to consent to medical or dental treatment or care for Minor under Section 6910 of the California Family Code. The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, or hospital care under the general or special supervision and upon the advice of or to be rendered by a physician or surgeon licensed under the Medical Practice Act and to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, or hospital care by a dentist licensed under the Dental Practice Act. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required, and is given to provide authority and power to render care which the aforementioned physician, in his or her best judgment may deem advisable. I further authorize Saddleback Church to receive physical custody of Minor under Section 1283(a) of the California Health and Safety Code upon completion of any treatment, and I specifically instruct any treating health facility to surrender the physical custody of Minor to Saddleback Church. I understand the nature to the event and do hereby release, on behalf of myself and Minor, Saddleback Church and its employees, staff, and volunteers from liability or claims arising from or related to the event.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Payment Information:  Cash  Credit Card  Check #: \_\_\_\_\_

Credit Card #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Zip: \_\_\_\_\_  
(\$30 SMALL GROUP Fee)